Fletcher Allen Health Care Report to the Vermont Division of Mental Health
October 31, 2005

The contract between the State of Vermont and Fletcher Allen Health Care (FAHC) requires that FAHC submit a report by October 31, 2005 reviewing the clinical standards at the Vermont State Hospital and designing a plan for improvement. The contract, which took effect on July 1, 2005, calls for FAHC to provide psychiatrists and psychiatric services to the hospital, as well as clinical leadership and guidance VSH. The state retained responsibility for administering VSH in compliance with all applicable laws and regulations and in accordance with established standards for similar psychiatric facilities.

This report is prepared with the input of clinicians, consumers, and advocates who are knowledgeable about past and present programs at the Vermont State Hospital. Some of the findings and recommendations require action on the part of the contractor, while others are offered in the spirit of providing clinical leadership and guidance in areas for which FAHC does not have direct responsibility. All of the recommendations in this report require collaboration between the state and FAHC. Although we have clarified responsibilities for particular proposed actions, we emphatically want to promote a collegial process that includes the state, VSH clinical staff, consumers, and the community—a process aimed at improving quality of care.

Since the first CMS decertification, several sequential action plans have been developed and implemented. There have been many changes in the programs and policies, and these continue to change on a daily and weekly basis as issues are addressed by the management of the hospital. It is not possible to create a static review of each process or practice.

Consequently, this report is conceived as a dynamic document which will serve to promote continuous quality improvement. It is organized in two parts. The first outlines broad recommendations to be implemented over the next four years. The second part describes a quality improvement process and is constructed like the Patient Problem List, a list of the current problems that require attention.

Broad Recommendations

Philosophy of Care

The Futures process has created a broad dialogue that has clarified clinical needs within the state and the expectations of the community. There are three important themes that emerged from this dialogue:

1. Assessment and treatment should be based on established best practices in mental health care. Programs should be based on interventions that are supported by empirical trials and scientific review.
2. The system of care should be developed with consumer and family input, should recognize the values of the community, including the civil rights of patients, and should ultimately be responsive to the needs of the community.
3. Although symptom reduction is usually a goal for acute inpatient care, the overall treatment should largely be conceived in a recovery model, incorporating the patient's own goals and preferences wherever practicable.

Inpatient Affiliations

The Vermont State Hospital, despite its crucial role in treating people with severe illness, has labored under the burden of isolation for many years. By comparison, an academic health center is linked to both the community it serves and to the national network of medical centers that aspire to provide the best patient care possible. Academic health centers lead in the development of best practices for patient care, teach the next generation of health care providers, and host programs that lead to the acquisition of new knowledge. We recommend that VSH adopt modern psychiatric practices and reap the benefits from affiliation with our academic health center. Among those benefits is the ability to recruit full-time academic psychiatrists and to integrate training of mental health professionals with our clinical delivery system.

Workforce and Leadership Development

It is critical to retain the professional staff now working at the Vermont State Hospital and to begin a systematic program of workforce development. This program should include the following elements:

1. Attention to the needs of existing staff, including work effort, compensation, deployment, safety, and numbers.
2. Recruitment of psychiatrists as University of Vermont faculty, to replace current locum tenens physicians.
3. Development of a plan that will address employment for nurses, social workers, psychologists, and psychiatric technicians once a site has been determined for the new hospital.
4. Review and enhancement of staff training.
5. Re-invigoration of the psychiatric technician training program
6. Integration with the University of Vermont Department of Nursing Psychiatric Nurse Practitioner Training Program.
7. Rotation of newly-hired psychiatrists at the FAHC units and VSH units.
8. More aggressive recruitment of needed nurses.

In addition, we recommend that leadership be strengthened, to expand expertise and to oversee the processes required to implement improvement, through the recruitment of three particular leadership positions. A Director of Hospital Services, a senior clinician

with extensive hospital management experience, is needed to manage and integrate the many clinical components of the hospital. An Assistant Director of Nursing should be recruited externally, with an emphasis on management experience in psychiatric hospitals. A psychiatric occupational therapist with knowledge of clinical recovery models should be recruited to review and revise clinical programming.

Decreasing Coercive Interventions

All programs should seek to minimize coercion in care; it is the policy of the general assembly to work towards a mental health system that does not require coercion or the use of involuntary medication. This includes minimization of seclusion, restraint, and involuntary medication and maximization of techniques that enhance motivation and encourage non-coercive interventions for change. This initiative should include the following elements:

1. Education of staff about existing recovery models and selection of program components to implement in the Vermont system of care.
2. Adoption of a single method of managing aggression at both FAHC and VSH with an emphasis on de-escalation techniques and a minimum of physical intervention.
3. Continuous monitoring of emergency involuntary interventions in a manner that clearly tracks and trends events.
4. Continued use of monitoring bodies (Emergency Involuntary Procedures Reduction Program, Quarterly Review Panel) to assure effective use of all available technologies to minimize the use of coercive interventions.
5. Attention to architectural elements that reduce aggression when designing the new units.
6. Reviewing staffing to ensure sufficient numbers

We believe that the single intervention that will have the biggest effect on reducing emergency coercive interventions below the current rate is the construction of new inpatient facilities. Reduction in crowding, creation of new space for patient use, and a change in the overall ambience are all likely to diminish aggression and tension in a complicated inpatient milieu. Until new facilities are built, other program elements can be strengthened to support this goal.

Maximizing Patient Preference

A recovery-oriented treatment approach relies on collaboration and trust, and offers informed choice. Better use of patient preferences should be developed as part of individual patient treatment planning. We recommend collaboration with Vermont Protection and Advocacy, Vermont Psychiatric Survivors, and other groups to develop a systematic and inclusive record of patient preferences so that they can be incorporated into individual treatment plans in inpatient settings and during crisis intervention in the community.

Quality Assurance

Variation in medical care can be minimized by quality assurance programs, and these must be expanded at VSH. Elements of quality assurance should include:

1. Development of standards based on best practice.
2. Identification of clinical practice or processes that deviate from standards.
3. Education of staff about standards of practice and expectations.
4. Selection of indicators to measure adherence to selected standards
5. Development of plans to improve identified outcomes.
6. Establishment of priorities for the development of these processes. Safety (e.g. suicide attempts, elopement, medication errors, environmental safety issues), coercion (seclusion, restraint, and involuntary medication), and clinical practice (e.g. compliance with treatment guidelines) are high priorities.
7. Other aspects of quality assurance include:
    a. A system of supervision for clinicians that should include both peer supervision and the oversight of junior clinicians.
    b. A systematic approach to tracking and trending critical events.
    c. Use of the Root Cause Analysis method to review critical events and to track improvement.
    d. Focus groups to measure patient satisfaction and concerns.

VSH has hired a quality consultant through FAHC who will be linked to both the management team at VSH and to the Institute for Quality and Operational Effectiveness at FAHC and UVM. This will ensure external review of the quality program, will coordinate measurement between FAHC units and VSH units, and will make FAHC information resources available to VSH. In addition, integration with the Quality Institute may lead to tracking of performance indicators not traditionally associated with Vermont State Hospital.

Behavior Therapy

The Department of Justice report criticizes a lack of individual behavior therapy plans for VSH patients. In particular, it cites repeated interventions with patients that do not result in improved behavior, without a provision to revise treatment. While behavior therapy or contingency management is not a required program component for inpatient psychiatry, it clearly has a role at VSH, where the goal of treatment goes beyond short-term stabilization with medication. One of the goals of such a program would be that the need to use emergency involuntary procedures for certain patients would be reduced. The treatment program should also aim to reduce seclusion and restraint. It is recommended that VSH add to its current psychology resources by hiring an expert psychologist with training and experience in the behavioral management of aggression in the inpatient setting.

In addition, VSH should rely on its psychological services in a more targeted way. VSH treatment teams should have ready access to a number of psychological services, including but not limited to:

1. individual behavior therapy plans
2. psychological testing (e.g. various personality, neuro-cognitive, and diagnostic inventories intended to complement the process of diagnosis and treatment)
3. neuro-psychiatric assessments
4. group therapies
5. individual therapies

These services would be used as clinically indicated so that all VSH patients could expect a thorough evaluation and well-informed treatment.

Review of Policies

The many institutional policies at VSH have been reviewed by multiple consultants and have been revised several times. In this process, the policies have been improved and corrected where shortcomings were identified. Now there is a need for a technical review of all of the policies to ensure internal consistency, completeness, compliance with law, preservation of civil rights, compliance with best clinical practice, and compliance with CMS and JCAHO standards.

1. A multidisciplinary group from FAHC with expertise on inpatient psychiatry policy should join VSH clinicians and administrators for this review.

2. This review is intended to provide professional recommendations to VSH leadership and the Division of Mental Health. It is recognized that additional comments may be submitted by the public and the state standing committee, and that regulations specify a formal process for final review and approval of policies.

3. The goal of this process will be to establish consistent policies governing clinical care at both the FAHC sites and the VSH sites. This will lead to policies that optimize clinical outcomes, optimize patient safety, and promote best practice. This will require expansion of FAHC policies that now do not address certain highly acute patients, incorporation of the best components into policies at both institutions, and modification of VSH policies to achieve consistency with FAHC.

Risk Management

Current VSH policies identify methods of reporting, monitoring, and responding to adverse events and safety risks. It is recommended that a standardized method for tracking, trending, and reporting critical incidents be adopted. Furthermore, we recommend that the adoption of this system be done in consultation with the Quality Institute.

Event reporting practices may change over time, but the overall goals are to use one method of tracking incidents; integrating the trending, reporting, and responding to data; making use of FAHC resources for staff education; and developing a common system to accomplish these tasks.

Integrated Medical Record

The routine care of serious and persistent mental illness in northwestern Vermont commonly involves staff at VSH, FAHC, the Crisis Service of Chittenden County, and Howard Center for Human Services. Treatment teams from multiple organizations commonly encounter an individual patient during an episode of care. In such instances, continuity of care cannot optimally be provided unless all relevant treatment teams are working from the same patient record.

Mental health care relies on subtleties of communication and extensive information about individuals. Despite enormous advances in information technology, the exchange of information about individual patients is typically inadequate and cumbersome.

We recommend that information technology staff at VSH and FAHC confer to adopt a common electronic repository for clinical records of patients treated with intensive services at FAHC, VSH, and HCHS. The record system should be accessible at each site and should be chosen to take advantage of emerging electronic medical record capabilities at the partnering institutions.

In addition, standardizing the data set will allow inpatient staff at both FAHC and VSH to use the same way of recording the initial assessment. This will serve to standardize the assessment process and to ensure inclusion of all required elements. A common record format will facilitate the transfer of patients between institutions and facilitate the sharing of staff between institutions, since staff will be familiar with the documentation technologies.

We recommend that VSH abandon further development of PsychConsult and link to emerging FAHC electronic medical record programs.

We recommend that the medical staffs at FAHC and VSH collaborate to design a single initial assessment protocol that is compatible with electronic records technology.

Education and Consultation

One of the advantages of affiliation with an academic health center is the availability of peer consultation, educational programs for clinical professionals, training for employees, and affiliation with the Institute for Quality and Operational Effectiveness. Our Grand Rounds series is already open to VSH psychiatrists and staff. We have the capability to broadcast Grand Rounds by video links to distant sites. We have deliberately added more topics related to public sector psychiatry in the future.

We recommend that telepsychiatry links and programs be established to:

1. Facilitate transfers of patients between the two facilities
2. To obtain consultations from psychiatrists at both facilities who have special expertise.
3. To routinely include VSH psychiatrists in the "Combined Rounds" program, a regular case conference historically held at the FAHC inpatient units with a faculty discussant.
4. To routinely include FAHC staff in the "Public Psychiatry Seminar Series," a regular didactic and case conference series held at VSH, focusing on topics of interest to public psychiatry.

Pharmacy

We recommend that VSH adopt modern pharmacy practices, including adoption of an electronic pharmacy management system. The pharmacy at VSH must be able to review individual medication regimens, identify drug-drug interactions for clinical staff, and confer with psychiatrists about medication changes and the need for laboratory monitoring associated with certain medications. The pharmacy management system should be capable of tracking pharmacy inventory, and it should be a source of date to assess prescribing practices at the hospital. Best practice also calls for automatic medication administration records.

Quality Improvement Problem List

Numerous quality issues have been identified by consumers, advocates, experts, and regulatory agencies. The leadership and staff at Vermont State Hospital have implemented many changes, some of them urgently, to address the most immediate problems and to ensure patient safety. There is a need now to plan for ongoing quality improvement. This requires that problems are regularly identified, ranked for priority, and addressed through a systematic process. Once programs or processes are changed, they must be monitored to ensure that the improvement is sustained.

In this report, we have selected 12 immediate problem areas that have been identified after external review and are a high priority for action now. Improvement efforts in these areas are at various stages of action planning. In some cases, interventions have been

implemented and the results measured. In other cases, no intervention has been developed.

These are obviously not the only 12 problem areas requiring attention. We must develop a culture whereby staff identify and bring forward processes and outcomes that should be improved.

We also need a systematic way to solicit problems and suggestions from community stakeholders. We propose that the Standing Committee solicit public input through its representative process with the goal of forwarding problems or areas for improvement to the management team.

The result of this process will be an active problem list, not unlike the problem list that physicians use to monitor the health of patients. We recommend that the list be maintained as a dynamic process.

By pursuing this path, we will accomplish three things:

1. We will address urgent problems now.
2. We will systematically review the corrective action that was implemented on an emergency basis in the past year.
3. We will introduce a process for quality improvement that will continue beyond the initial emergency period.

Problem # 1 Psychiatrist staffing at VSH is inadequate.

Goal: Develop a stable workforce of psychiatrists, recruiting as many full-time faculty positions as possible.

Objectives:

1. Recruit two full-time faculty psychiatrists to work during business hours by July 1, 2006.
2. Recruit one full-time faculty psychiatrist to provide overnight coverage by July 1, 2006.
3. Develop a pool of contracted psychiatrists to cover any remaining nights, weekends, or holidays effective immediately.

Interventions: UVM approval of these faculty positions is complete, and a pool of applicants has been developed. Applicants will be selected according to UVM standards for the hiring of faculty. Recruitment of academic psychiatrists is the responsibility of FAHC.

Problem #2 Nursing staffing is inadequate

Goal: Recruit and retain an adequate nursing staff, and support strong leadership for nurses

Objective:

1. Recruit 13 additional Psychiatric RN's for a total of 33 FTE's on the two acute units and 8 FTE's on Brooks Rehab.
2. Recruit 5 additional LPNs for a total of 10 to augment RN staffing
3. Maintain 40 Psych Techs
4. On Brooks I (21 beds), maintain four RN's on day shift, four RN's on evening shift, and three RN's on night shift. Maintain one LPN per shift.
5. On Brooks II (18 beds), maintain three RN's on day shift, three RN's on evening shift, and two RN's on night shift. Maintain one LPN per shift.
6. Brooks Rehab staffing is unchanged (total of eight FTE's).
7. Psych tech staffing should mirror RN staffing on each unit.
8. Recruit an experienced Assistant Director of Nursing
9. Collaborate with the FAHC Psychiatry Nurse Manager to establish joint training programs and cross training of nurses.

Interventions: Responsibility for the development of the nursing staff remains with the VSH Executive Director. We recommend that advertising for positions continue with out-of-state ads and discussion with the UVM School of Nursing. Potential nurse recruits may be attracted by the expectation that positions will shift to new facilities within five years.

Problem #3 Quality Improvement Systems at VSH are inadequate

Goal: Develop Quality Improvement and Patient Safety systems consistent with national standards.

Objectives:

1. Utilize FAHC's Quality Consultant model and establish a "Quality Consultant" role to liaison directly with VSH. This individual will serve as the primary resource for quality activities for VSH.
2. Support for the Quality Consultant will be offered through a collaborative relationship with the FAHC Institute for Quality and Operational Effectiveness.
3. A management team including the VSH Medical Director, VSH Executive Director, and FAHC Psychiatry Physician Leader will identify priority areas for improvement and charter teams to implement improvement plans.
4. The teams will utilize performance improvement methodologies and identify measures to track improvement over time for each identified priority area.

Interventions: The Quality Consultant has been hired. This position was filled on October 15, 2005. The VSH Executive Director retains authority for ultimate adoption of recommended policies.

Problem # 4 The Risk Management System at VSH is inadequate

Goal: Develop a Risk Management system and patient safety program consistent with national standards.

Objectives:

1. Adopt a standardized event tracking system at VSH in order to report, track, and trend incidents of
    a. Patient injury
    b. Staff injury
    c. Elopement
    d. Suicidal behavior
    e. Falls
    f. Medication Errors

2. Review, revise, or create policies and practices to identify, record, and track contraband in the hospital.

Interventions: The Executive Director of VSH can coordinate with the Institute for Quality and Operational Effectiveness to adopt the event tracking system. A QI team should be developed to assess the issue of contraband, review existing policies, make recommendations, and recommend quality indicators.

Problem #5 Seclusion and restraint have historically not complied with patient rights

Goal: Incorporate public input into a written strategy related to involuntary procedures, with the goal of balancing patient rights and clinical needs with a minimum of involuntary intervention.

Objectives:

1. Adopt the National Association of State Mental Health Program Directors (NASMHPD) position statement on seclusion and restraint as guiding principles for practice at VSH.
2. Engage the assistance of the Standing Committee to capture additional clinical and consumer views related to involuntary interventions, with the possibility of customizing the NASMHPD position statement.
3. Review all policies on restraint and seclusion, convene a multidisciplinary group to ensure that practice is consistent with federal law and JCAHO standards, and consolidate multiple policies into one clear document.
4. The resulting policy must:

    a. Define each restrictive practice
    b. Define the role of each discipline in initiating, authorizing, and continuing a restrictive practice
    c. Establish criteria for discontinuation
    d. Establish criteria for initial and ongoing assessments of patients in restraints
    e. Establish criteria for the use of each restrictive practice
5. Adopt a single method for de-escalation and behavioral management of aggressive behavior, then
    a. Train staff in that model.
    b. Train staff in safely applying and discontinuing restrictive measures.
6. Review standards for documentation of patient behavior and staff response.
7. Continue to monitor restraint and seclusion rates and practices, analyzing findings in the Emergency Involuntary Procedures Reduction Project meetings and the Quarterly Treatment Review Panel meetings.
8. Revise policies, by a process of continuous quality improvement, if rates of seclusion and restraint do not diminish with existing interventions.

Interventions:

The Emergency Involuntary Procedures Reduction Project (a collaboration between clinicians, VP&A, and VPS) will review results and practices adopted to date against the objectives outlined above, and will develop a work plan for any areas that require additional attention. Physician practice related to seclusion and restraint is the responsibility of FAHC. All policies must be approved by the VSH Executive Director, who will also oversee implementation.

Problem #6 Diagnoses have not historically been uniformly validated and substantiated with clinical data.

Goal: Each diagnosis will be substantiated in the clinical record, will be as precise as possible, and will be accurate in relation to criteria set forth in the Diagnostic and Statistical Manual, Fourth Edition

Objectives:

1. Verify that the discharge diagnosis is supported by clinical information, documented in the record, in 95% of discharged cases.
2. Verify that diagnostically challenging cases include documentation reflecting the diagnostic quandary and relating the clinician's reasoning in 95% of cases that are discharged with a provisional or NOS diagnosis.
3. Reduce the number of provisional, "rule out," and "NOS" diagnoses assigned as discharge diagnoses to a level not to exceed 5% of all discharges.

Interventions:

1. The VSH Medical Director, or his designated senior psychiatrist, will review all patient diagnoses and will provide supervision and education to staff psychiatrists related to accuracy of diagnosis.
2. Psychiatrists will routinely participate in Combined Rounds to share their diagnostic and therapeutic challenges.
3. Medical Director supervision will include a review of documentation and a record of compliance with diagnostic documentation expectations.
4. The Quality Consultant will develop a record of types of discharge diagnoses.

Problem #7 Treatment plans for individual patients have historically been unclear

Goal: Treatment Planning must be multi-disciplinary, tailored to each individual patient, and clearly documented

Objectives:

1. The treatment planning process will comply with CMS and JCAHO standards, including documentation of the short term and long term goals for each patient, interventions needed to reach those goals, and the role of each team member in the treatment plan.
2. Audits of the treatment planning documents will show a 98% completion rate.

Interventions:

1. The Medical Directors at VSH and FAHC will collaborate to create single Treatment Planning Process and a single method of documentation.
2. The Quality Consultant will develop a method for auditing treatment planning documents.

Problem #8 Treatments, particularly medication interventions, have not historically necessarily conformed to clinical algorithms or practice guidelines

Goal: All treatments offered will be supported by evidence of effectiveness and safety

Objectives:

1. The treating psychiatrist will continuously review each medication to determine if it has conferred benefit for the patient
2. Pharmacologic interventions will be informed by practice guidelines or other acknowledged professional consensus.
3. Audits of treatment interventions will show substantial agreement with clinical practice guidelines.

Interventions:

1. The Medical Director will make treatment guidelines available to staff psychiatrists.
2. Psychiatric supervision will include comparison of chosen treatments to the best practice as identified by published practice guidelines.
3. Deviations from practice guidelines will be documented and explained in the medical record.

Problem #9 Psychologists historically have not created behavior plans for aggressive behavior

Goal: Use effective behavior plans to minimize aggression, minimize medication, minimize emergency involuntary interventions, and shorten hospital stays.

Objectives:

1. Routinely identify all patients who require a behavioral treatment plan as part of the Initial Multidisciplinary Treatment Planning process.
2. The behavioral psychologist will develop a written behavior plan for those patients.
3. Demonstrate that behavior plans are discussed at team rounds with the expectation that all staff will respond to patients in a way that is consistent with the plan.
4. Establish a method of reviewing key outcomes for individual patients so that behavior plans are revised if they are ineffective.

Interventions:

1. Recruit a new psychologist with expertise in the behavioral management of aggressive patients.
2. Train current employed psychologists in contingency and behavior management.
3. Psychologists do not report to FAHC, so implementation of these recommendations is at the discretion of the VSH Executive Director.

Problem #10 The environment of care is poor

Goal: Confirm that all remediable deficiencies in the environment of care have been identified and repaired

Objectives:

1. Identify all deficiencies in the environment, noting those that create a safety hazard for patients.
2. Determine the costs and benefits and addressing each deficiency.
3. Recommend to the Department of Health those areas that should be addressed even during the period of transition to a new facility.

Interventions: Many improvements in the environment of care have been made, but it is not clear that external observers have the opportunity to compare completed and planned improvements with those deficiencies identified by external consultants. Review and correction of environment of care remain the responsibility of the state.

Problem #11 Current physician documentation in the medical record does not meet CMS standards.

Goal: Ensure that physician documentation meets all CMS and JCAHO standards

Objectives:

1. Each acute patient will have a physician progress note in the chart five days per week.
2. Each sub-acute patient will have a physician progress note in the chart two days per week.
3. All progress notes will comply with documentation requirements set forth in the latest edition of the Current Procedural Terminology Manual.

Interventions:

1. The existing psychiatrists will be expected to transition to this standard.
2. Newly-hired psychiatrists will be expected to meet this standard as they start practice.
3. FAHC retains responsibility for this improvement project.

Problem #12 The treatment model at Vermont State Hospital is not optimal for all the patient populations treated there, and it has not sufficiently incorporated a recovery model of care. Psychotherapy, occupational therapy, dual diagnosis treatment, motivational treatments, and skill building are not adequate to treat medication-resistant patients who require longer hospitalization.

Goal: Incorporate recovery principles into the treatment program at Vermont State Hospital and develop a range of therapies appropriate for this patient population.

Objectives:

1. Identify best practices for psychosocial treatments for persistent mental illness requiring long hospitalization.
2. Identify treatment alternatives for patients who have a poor response to medication, do not tolerate medication, or choose not to take medication.
3. Develop a program track for these patients, integrating it with the program developed for sub-acute rehab programs.

Interventions:

1. Work in conjunction with ADAP to develop and maintain more robust substance abuse programming at VSH.
2. Consult with the Standing Committee to choose pilot programs to test at VSH
3. Recruit an experienced psychiatric occupational therapist to lead the initiative to develop new programming in the recovery model.
4. These interventions require the approval of the VSH Executive Director.